

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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February and March 2006

Recommended Childhood and Adolescent Immunization Schedule United States, 2006

The Advisory Committee on Immunization Practices (ACIP) periodically reviews the recommended childhood and adolescent immunization schedule to ensure that the schedule is current with changes in vaccine formulations and reflects revised recommendations for the use of licensed vaccines, including those newly licensed. ACIP,

the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) approved the recommendations and format of the childhood and adolescent immunization schedule and catch-up schedule for January-December 2006.

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Lunar New Year Travel Advisory: Increase Awareness and Surveillance for Avian Influenza

The end of January marks the Chinese Lunar New Year. In celebration, Los Angeles area residents will likely travel to or entertain guests from areas afflicted by avian influenza—as such, increase surveillance for potential human cases of influenza A (H5N1) is critical. While the CDC has not recommended travel restrictions, they have published a health advisory for travelers (see box on page 2); this includes viewing the CDC web site to receive the

most current guidelines on travel recommendations and disease risks (www.cdc.gov/travel).

While human infections with avian influenza A (H5N1) have been rare, as of January 2006, the World Health Organization has confirmed 148 cases and 79 deaths in 6 countries and the virus has been identified in birds in 17 countries. Healthcare professionals should be especially vigilant in compiling a complete case history (including travel history and potential exposures) of their patients who present with severe flu-like symptoms. Since the epidemiologic factors that increase risk for avian influenza change frequently, consultation with Acute Communicable Disease Control is essential to provide advice on diagnostic testing and specimen collection.

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**Any suspected human case
of avian influenza should be
reported immediately to
Acute Communicable Disease Control
213-240-7941**

***For Infant Botulism Testing please call (510) 231-7600
See page 15 for more details***

THE PUBLIC'S HEALTH



COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

313 North Figueroa Street, Room 212
Los Angeles, California 90012

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CONTRIBUTORS TO THIS ISSUE:

David E. Dassey, MD, MPH
Deputy Director, Acute Communicable Disease Control

Alvin Nelson El-Amin, MD, MPH
Medical Director, Immunization Program

Brit Oiulfstad, DVM, MPH
Veterinarian Medical Epidemiologist, ACDC

Jorge A. Montoya, PhD,
Director of Communications & Program Evaluation Sexually Transmitted Disease Program

Ben Techagaiciyawanis, MPH, CHES
Senior Health Educator, Acute Communicable Disease Control

Amy Rock Wohl, MPH, PhD
Chief Epidemiologist

Lunar New Year Travel Advisory...from page 1

Suspected human cases of avian influenza should have:

1. Radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, **AND**
2. A history of travel within 10 days of symptom onset to a country with documented H5N1 avian influenza in poultry and/or humans. As of January 2006, current countries of concern include: Cambodia, China, Croatia, Hong Kong, Indonesia, Japan, Kazakhstan, Korea, Laos, Malaysia, Mongolia, Romania, Russia, Thailand, Turkey, Vietnam.

Testing for influenza A (type H5) will be considered on a case-by-case basis for patients with:

3. Documented temperature of $>38^{\circ}\text{C}$ ($>100.4^{\circ}\text{F}$), **AND**
4. One or more of the following: cough, sore throat, shortness of breath, **AND**
5. A history of:
 - contact with poultry (e.g., visited a poultry farm or bird market, household raising poultry, etc.) **OR**
 - contact with a known or suspected human case of influenza A (type H5) within 10 days of symptom onset.

Avian Influenza Travel Recommendations*

Before travel to areas affected by avian influenza:

- Visit the CDC web site for the latest travel health recommendations and information about avian influenza.
- Stay up to date on all necessary vaccinations and travel medications.
- Create a traveler's health kit containing basic first aid and other medical/health supplies (e.g., thermometer, alcohol hand gel, etc.). See the CDC's "Traveler's Health Kit" for recommendations.⁺
- Identify a doctor in the country you will visit in case you become ill.

During travel to areas affected by avian influenza:

- Avoid contact with poultry (as well as poultry feces or secretions) including places that raise or keep poultry such as markets and farms.
- Wash your hands routinely; use alcohol-based hand gels for situations when soap and water are not readily available.
- Ensure all foods (especially poultry, eggs and poultry blood) are thoroughly cooked.
- If you become sick while traveling, the CDC traveler's health advisory web site can provide guidance for seeking healthcare while abroad.⁺

When you return:

- Monitor your health for at least 10 days.
- If you become ill with a fever plus other respiratory symptoms (e.g., cough, sore throat, difficulty breathing, etc.) see your doctor immediately. Before your visit, let them know:
 - your symptoms
 - where you traveled, and
 - if you had direct contact with poultry or any other very sick people. This is to ensure that your doctor is aware of your potential exposure to avian influenza and can properly direct your care.
- If you become sick when you return, do not go out unless it is to seek medical care and avoid contact with others. This is to limit the spread of infection to others.

* Adapted from: www.cdc.gov/travel/other/avian_flu_lunar_newyear_2006.htm.

+ For more information visit: www.cdc.gov/travel/index.htm.

Childhood and Adolescent Immunization Schedule...from page 1

The changes to the previous childhood and adolescent immunization schedule, published January 2005, are as follows:

- The importance of the hepatitis B vaccine (HepB) birth dose has been emphasized. Vaccination of infants born to hepatitis B surface antigen (HBsAg)-negative mothers can be delayed in rare circumstances, but only if a physician's order to withhold the vaccine and a copy of the mother's original HBsAg-negative laboratory report are documented in the infant's medical record. Administering four doses of HepB is permissible (e.g., when combination vaccines are administered after the birth dose); however, if monovalent HepB is used, a dose at age 4 months is not needed. For infants born to HBsAg-positive mothers, testing for HBsAg and antibody to HBsAg after completion of the vaccine series should be conducted at age 9-18 months (generally at the next well-child visit after completion of the vaccine series).
- A new tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine recommended by ACIP for adolescents (Tdap adolescent preparation) was approved by the Food and Drug Administration (FDA) on May 5, 2005, for use in the United States. Tdap is recommended for adolescents aged 11-12 years who have completed the recommended childhood diphtheria and tetanus toxoids and pertussis/diphtheria and tetanus toxoids and acellular pertussis (DTP/DTaP) vaccination series and have not received a tetanus and diphtheria toxoids (Td) booster dose. Adolescents aged 13-18 years who missed the age 11-12-year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent Td boosters are recommended every 10 years.
- Meningococcal conjugate vaccine (MCV4), approved by FDA on January 14, 2005, should be administered to all children at age 11-12 years as well as to unvaccinated adolescents at high school entry (age 15 years). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated with MCV4 or meningococcal polysaccharide vaccine (MPSV4). For prevention of invasive meningococcal disease, vaccination with MPSV4 for children aged 2-10 years and with MCV4 for older children in certain high-risk groups is recommended.
- Influenza vaccine is now recommended for children aged 6 months (and older) with conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration.
- Hepatitis A vaccine is now universally recommended for all children at age 1 year (12-23 months). The 2 doses in the series should be administered at least 6 months apart. States, counties, and communities with existing Hepatitis A vaccination programs for children 2-18 years of age are encouraged to maintain these programs (this would include California).
- The catch-up schedule for persons aged 7-18 years has been changed for Td; Tdap may be substituted once for any dose in a primary catch-up series or as a booster if age appropriate for Tdap. A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose.

The National Childhood Vaccine Injury Act requires that healthcare providers provide parents or patients with copies of Vaccine Information Statements (VIS) before administering each dose of the vaccines listed in the schedule. Additional information is available from Los Angeles County Immunization Program at (213) 351-7800 and from CDC at <http://www.cdc.gov/nip/publications/vis>.

***See Immunization Schedule
on pages 14 and 15***



ANTIBIOTIC RESISTANCE INFORMATION CORNER

Relation of Time Spent in an Encounter With the Use of Antibiotics in Pediatric Office Visits for Viral Respiratory Infections

Coco A, Mainous AG. Arch Pediatr Adolesc Med. 2005 Dec;159(12):1145-9.

Available at: <http://archpedi.ama-assn.org/cgi/content/full/159/12/1145>

Every year, millions of antibiotics are prescribed inappropriately for upper respiratory viral infections; this offers no benefit to patients while contributing to the problem of antibiotic resistance. Reasons cited by doctors for over-prescribing antibiotics include diagnostic uncertainty, patient demand and time pressure on physicians.

This study was conducted to determine whether prescribing antibiotics for viral infections actually leads to shorter visits that save time. In an analysis of pediatric ambulatory care visits to U.S. physicians, 27% of those with a cold were given antibiotics and 46% of those with bronchitis were also given antibiotics. No difference was found in the mean time a physician spent with patients when comparing visits between the receipt (14.24 minutes; SE = 0.85) and the non receipt (14.18 minutes; SE = 1.03) of an antibiotic prescription ($p = 0.95$). Researchers also found that "the prescription of antibiotics was not associated with whether the time a physician spent with a patient was above or below the median encounter time of 15 minutes."

Results show that prescribing antibiotics for children with viral respiratory infections does not reduce the time a physician spends with the patient.

Online Resources:

- Infectious Diseases Society of America — www.idsociety.org
- Clinical Practice Guidelines — www.journals.uchicago.edu/IDSA/guidelines
- California Medical Association — www.aware.md/resource/index.asp
- Clinical Practice Guidelines Compendium (Pediatric and Adult) — www.aware.md/clinical/clinical_guide.asp
- Centers for Disease Control and Prevention — www.cdc.gov/drugresistance/community/
- Acute Communicable Disease Control Program
— www.lapublichealth.org/acd/antibiotic_resistance/antibio_Clinician.htm

Rabies Control and Prevention

While advances in public health have made rabies (both human and animal infections) less common, cases continue to emerge. The most likely potential exposure to rabies in Los Angeles County is through bats. During the summer of 2005, 13 rabies-infected bats were identified by the Los Angeles County Department of Health, which had the potential of infecting numerous other animals and people. During the 21st century, bats have accounted for the majority of human rabies cases in the United States and California. Rabies virus transmission can occur from very minor or even unrecognized bite—bat bites may not leave any evident mark and often a limited recall of exposure can inhibit proper diagnosis of bat-based rabies exposure. As such, healthcare providers should inquire about and discourage all human contact with bats.

In addition, rabies is enzootic in many countries (e.g., El Salvador, Guatemala, Mexico) whose citizens frequently visit or immigrate to the Los Angeles area. Similarly, the importation of potentially infected animals also is a common occurrence that should not be overlooked. In 2004, Acute Communicable Disease Control investigated two separate incidents involving the importation of pets with factors consistent with rabies infection. And in March 2005, the first Los Angeles County human rabies case in 30 years was identified—this case likely contracted rabies in his hometown of El Salvador.* During all these events, many individuals were potentially exposed to rabies and required prophylaxis.

Thus, rabies continues to be an important and viable differential diagnosis in both humans and animals in Los Angeles County. Any suspected human or animal case should be reported immediately to Public Health. Prompt reporting is mandated and

To obtain assistance with rabies treatment decisions or to refer an uninsured patient for treatment call: Acute Communicable Disease Control (213) 240-7941

critical to assist with the diagnosis and to administer prophylaxis as needed.

The most current recommendations for the control and prevention of rabies (from 2004) are available at: www.dhs.ca.gov/ps/dcdc/disb/pdf/2004%20CA%20Rabies%20Compendium.pdf or by calling the California Department of Health Services Veterinary Public Health Section (916-327-0332). Included are important guidelines for human rabies postexposure prophylaxis the appropriate administration of human rabies immune globulin (HRIG) and rabies vaccine.

Beyond postexposure treatment, preexposure vaccination should be encouraged to all persons at increased risk of rabies exposure. This includes: veterinarians, animal handlers, animal control officers,

Continued on page 6

In March 2005, the first Los Angeles human rabies case in 30 years was identified.



*Described in the March 2005 the Public's Health. Available at: <http://www.ladhs.org/media/tph/TPHmarch2005.pdf>

Reporting Animal Bites

Animal bites can cause serious injury, bacterial and viral infections, physical and psychological trauma, and even death.

As such, it is critical to public health to obtain an accurate account of all animal bites that occur in our county.

Information for reporting animal bites is available by phone 877-747-2243 Rabies Hotline or can be completed on-line through our secure website: www.lapublichealth.org/vet/biteintro.htm

laboratory workers with potential exposure to rabies virus, and persons traveling to and spending time (e.g., >1 month) in foreign countries where rabies is endemic. Preexposure vaccination should also be considered for persons whose habits and hobbies may expose them to potentially rabid animals (e.g., bats, skunks, etc.). The advantage of preexposure prophylaxis

is the protection of persons with unrecognized rabies exposure. In addition, it simplifies and saves money inherent in rabies postexposure treatment. This also may protect persons exposed in areas where immunizing products are not available or when treatment may be delayed (e.g., travelers).

Rabies Biologics – United States

Type	Product Name	Manufacturer
Human Rabies Vaccine		
Human diploid cell vaccine (HDCV) - Intramuscular - Intradermal (for pre-exposure ONLY)	Imovax® Rabies Imovax® Rabies I.D.	Aventis Pasteur, Inc. (800) 822-2463 www.aventispasteur.com
Purified Chick Embryo Cell Culture (PCEC) - Intramuscular (not approved for intradermal)	RabAvert™	Chiron Vaccines (800) 244-7668 www.rabavert.com
Rabies Vaccine Adsorbed (RVA) - Intramuscular (not approved for intradermal)	RVA	BioPort Corporation (517) 327-1500 www.bioport.com

(All three types of vaccine are considered equally efficacious and safe when used as indicated.)

Human Rabies Immune Globulin (HRIG)

	BayRab™	Bayer Corporation Pharmaceutical Division (800) 288-8370 www.bayer.com
	Imogram® Rabies-HT	Aventis Pasteur, Inc. (800) 822-2463 www.aventispasteur.com

(Both types of HRIG are considered equally efficacious and safe when used as indicated.)

Preventing Childhood Motor Vehicle Occupant Injury: What Physicians Can Do

Motor vehicle occupant injuries remain one of the leading causes of death and hospitalization among children in Los Angeles County. Between the years 1993-2003, 3,361 children (ages 0-12) were injured from motor vehicle occupant crashes and another 264 died from these crashes.

The greatest risk factor for death and injury among child occupants of motor vehicles is riding unrestrained. In 2003, of all motor vehicle occupant injuries among children (ages 0-12) alone, 27% sustained head and neck injuries, 24% traumatic brain injuries, 16% injuries to the torso, and the remaining sustained injuries to the upper and lower extremities.

It is estimated that 82% of children placed in a child safety seat are improperly restrained. The California Highway Patrol says more than 80% of the children, under the age of four killed in crashes since 1990, and would have survived if they were buckled up properly in a child safety seat or booster. When used properly, child safety seats and booster seats can reduce the risk of fatal injury by 70% for infants and 55% for toddlers.

California Child Passenger Safety Law requires children be properly secured in a child seat or booster seat until they are at least 6 years old or weighing at least 60 pounds. Children under 16 years of age but at least 6 years old or 60 pounds are required to ride in either a child restraint system (car seat, booster, harness, or other product certified to meet Federal Safety Standards), or a properly fitted safety belt (lap belt touching the thighs and shoulder belt on child's shoulder, not under their arm or behind their back).

National Child Passenger Safety Week: February 13, 2006.

Physicians can help to reduce occupant injuries by reminding parents of these prevention tips:

- Make sure every passenger is buckled up for safety and all children are properly restrained
- Children 12 years old and under should always ride properly secured in the back seat. The front

seat is a dangerous location and upon deployment, air bags can seriously hurt and even kill a child

- ALWAYS read the child safety seat instruction manual and your motor vehicle owner's manual to ensure proper installation
- Contact the National Highway Traffic Safety Administration's Auto Safety Hotline (888) 327-4236, U.S. Consumer Product Safety Commission (800) 638-2772 or www.cpsc.gov, about recalls or safety notices on safety seats. After you purchase a new child safety seat, return the product registration form to the manufacturer so you are notified of recalls.
- Child safety seats and vehicles manufactured after 2002 are equipped with LATCH (Lower Anchors and Tether for Children). The bottom of the safety seat is connected by straps with hooks to two bars in the crack of the vehicle seat cushion. If LATCH is not available on both the safety seat and the selected seating position in the vehicle, use the vehicle belt instead. In either case, the top tether strap should be attached for forward-facing seats.

For more information, visit DHS' Injury and Violence Prevention website at <http://lapublichealth.org/ivpp>.



Epidemiology & Prevention of Traumatic Brain Injury: How Physicians Can Help

Motor vehicle crashes, falls, and sport related injuries are common causes of Traumatic Brain Injury (TBI). Unlike other types of injuries, an injury to the brain can result in long term disability. A TBI is a physiological disruption of brain function due to an internal (acceleration or deceleration of the brain within the skull) or external trauma (external force or impact striking the head). Among the two types of brain injuries, open (lacerations due to penetration for example) and closed head injuries, closed head injuries are most common. Closed head injuries are the result of rapid movement of the head where the brain is bounced back and forth within the skullcap.

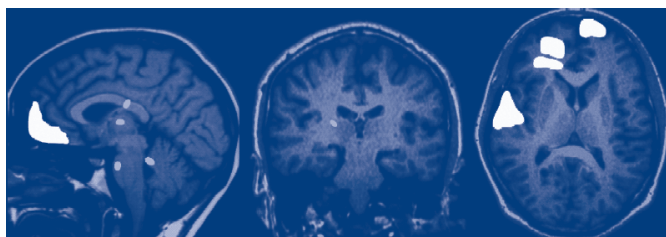
It is estimated that every 15 seconds, someone in the United States sustains a TBI. Each year, approximately 1.4 million people sustain a mild to severe TBI in the United States. Of these, 50,000 result in fatalities, 80-90,000 people experience long-term disability from severe TBI, 235,000 result in hospitalizations from moderate to severe TBI, and 1-1.5 million are treated in emergency rooms with mild TBI, then released. - In many cases, people with mild TBI may never even receive medical attention or be hospitalized. It is estimated that 5.3 Million people in the US, live with TBI-related disabilities, an estimated 2% of the U.S. population - The cost of TBI in the United States is estimated at \$48 billion annually, with TBI hospitalizations at \$31 billion and fatal TBI at \$16 billion.

In 2003, in Los Angeles County 6% (4,435) of all hospitalized injuries (N=86,427) were due to TBI. Among all TBI related hospitalizations 87% were unintentional, 12% intentional and 1% other. Among the 87% of unintentional related TBI hospitalizations, the causes were 51% due to falls, 34% due to motor vehicle crashes, and 15% other. The rate of fall-related TBI are highest for those under the age of one (72/100,000) and those 75 years of age and older (133/100,000). Among motor vehicle-related TBI hospitalizations, rates were greatest for those aged 15-24 (17/100,000). Among all ages for motor vehicle-related TBI, 60% were occupant, 23% pedestrian, 7% bicycle, 6% motorcycle, 3% unspecified, and 1% other. Among the 12% intentional related TBI

hospitalizations, 96% were caused by assault/homicides. The percent of TBI-related homicide/assault by method include, 32% blunt object, 30% fight/unarmed, 21% other, 12% firearm, 3% abuse/neglect, and 2% cut/pierce. The cost of TBI related hospitalizations for 2003 cases in Los Angeles County include 60% Medicare, Medi-Cal or other Government, 27% private insurance, 11% uninsured, and 2% unknown.

It is estimated that during the 30-seconds it took to read the above statistics, that two people in the United States will have sustained a TBI. The chronic effects of TBI can affect people differently depending on its severity, ranging from emotional to cognitive consequences. Emotional symptoms include being anosognosic (lack of awareness or insight to their own condition.), increased anxiety, depression/mood swings, impulsive behavior, easily agitated, difficulty in controlling urges (disinhibition) to lack of initiating/completing activities. Cognitive symptoms are varied and include headaches, fatigue, vertigo, aphasia, diplopia, seizures, dysphagia, memory loss, sleep problems, spatial disorientation, an inability to focus, difficulty in concentrating or paying attention for greater periods of time, a slowed ability to process information, and difficulty in maintaining a conversation.

Contusions on the frontal and temporal lobes as shown, are common neuropathological findings associated with moderate to severe TBI



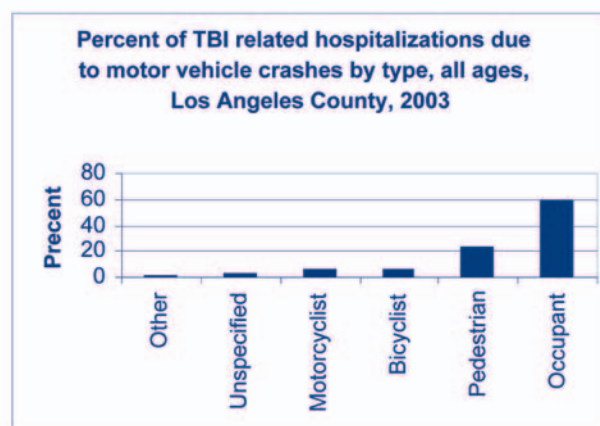
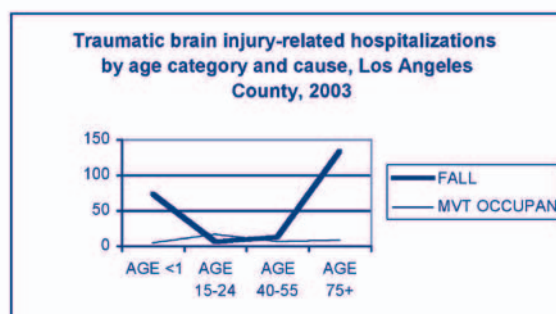
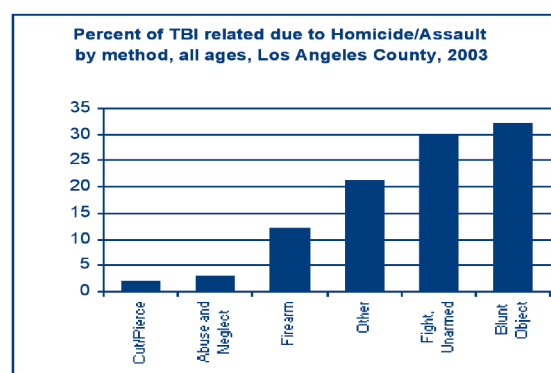
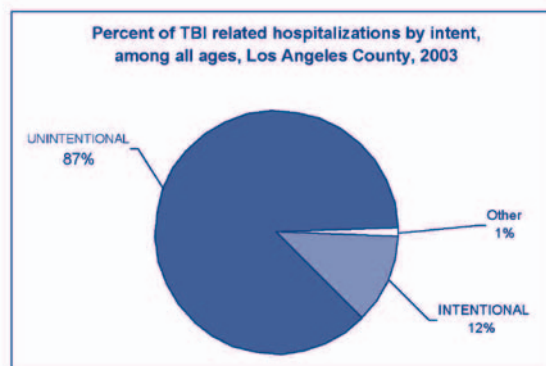
Barrow Neurological Institute (Printed with permission)

Traumatic Brain Injury...from page 8

As observed from TBI-related hospitalizations, the leading cause of TBI is motor vehicle crashes, followed by falls, and assaults. Once a person sustains a TBI, the risk for a second TBI increases by three times and after a second TBI, the risk increases by eight times. Among all ages, the risk of sustaining a TBI are twice as likely among males compared to females, due to risk exposure differences. The risk for sustaining a TBI is highest among young adolescents, young adults, and the elderly 75 years and older. Alcohol is a major contributing factor in the occurrence of TBI cases, with more than half of the people who sustained a TBI being intoxicated at the time of injury. -

March 2006 is Brain Injury Awareness Month. Physicians can help to reduce the occurrence of TBI by helping to increase awareness by educating their patients about injury risks and prevention.

- Wear a seat belt every time you drive or ride in a vehicle
- Always buckle your child properly in a child safety seat, booster seat, or seat belt (According to the child's height, age, and weight) every time they ride in a vehicle
- Never drive after drinking alcohol or using drugs
- Wear a properly fitted and fastened helmet every time you and your children:
 - Ride a bicycle, motorcycle, snowmobile, or all-terrain vehicle
 - Ride a horse
 - Ride a skateboard or use in-line skates
 - Ski or snowboard
 - Bat and run bases in baseball or softball
 - Play contact sports, such as ice hockey, football, boxing, etc.
- Avoid falls in your home by:
 - Using non-slip mats on the bathtub and shower floor
 - Using safety gates at the top and bottom of stairs when young children are around
 - Installing handrails on stairways
 - Installing grab bars in the bathtub and shower and next to the toilet



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Traumatic Brain Injury...from page 9

- Having your doctor review your medication for possible balance risks if you are an older adult taking many medications
 - Having regular vision checks
 - Installing window guards to keep young children from falling out of open windows
 - Removing tripping hazards, such as small rugs and loose electrical cords
 - Maintaining exercise and physical activity to improve strength, balance and coordination
- For additional information, physicians can order

“Heads Up: Brain Injury in Your Practice”, a TBI prevention kit free of charge that includes easy to apply clinical information, patient information in English and Spanish, scientific literature review, and a CD-ROM by calling or emailing the National Center for Injury Prevention and Control at (770) 488-1506 or OHCINFO@cdc.gov. An electronic downloadable version is also available at <http://www.cdc.gov/ncipc/pub-res/pubs2.htm>.

2006 Survey: Needs and Experiences of People Living with HIV/AIDS

The Medical Monitoring Project (MMP) is a CDC-funded study of people with HIV and AIDS, and will be conducted beginning in January 2006 in Los Angeles County and 25 other U.S. sites. MMP is the first research study since the HIV Cost and Services Utilization Study (HCSUS) conducted in the mid-1990's to collect information from a nationwide representative sample of people receiving HIV care. MMP was designed by HCSUS investigators at the RAND Corporation, currently serving as consultants to the CDC on this project. The County survey will be conducted by DHS' HIV Epidemiology Program.

The MMP is designed to identify a representative sample of HIV-positive persons in care to provide quality data for care and prevention planning. The objectives of MMP are to use a population-based sampling method to collect information from HIV-infected persons in care on healthcare utilization, disease outcomes, and risk behaviors; monitor and calculate rates of opportunistic infections among HIV-infected persons; determine the prevalence of adverse events to pharmacologic therapy; determine the

prevalence of resistant strains of HIV; assess the impact of behavioral determinants in access to care and in adherence to medical regimens for HIV-positive persons; improve prevention programs to reduce further HIV transmission; and improve services for those already infected.

This confidential study is cross-sectional in design and will survey persons with HIV/AIDS who are 18 years of age and older, live in Los Angeles County, and

This confidential study is cross-sectional in design and will survey persons with HIV/AIDS who are 18 years of age and older, live in Los Angeles County, and receive care at the 25 facilities sampled for the 2005-2006 cycle.

receive care at the 25 facilities sampled for the 2005-2006 cycle. The sampled provider sites will determine the method for contacting patients included in the patient sample. Institutional

Review Board approval will be obtained prior to any data collection activities. Participating patients will be given informed consent and HIPAA documents to sign. Subsequently, participants will complete an hour-long interview and their medical records will be abstracted. MMP participants receive a \$25.00 reimbursement for their time spent completing the interview.

Poison Prevention: What Can Physicians Do?

U.S. poison control centers report nearly 2.2 million poison exposures each year. In California, the California Poisons Control System received 306,892 exposure calls in 2002. It is estimated that one poisoning exposure occurs every 15 seconds with 90% occurring in the home and approximately 51% among children 5 years of age and younger. In 2003, poisonings among all ages in the county remain among the top five injury-related hospitalizations and fatalities.

A 'poison exposure' is defined as "the ingestion of or contact with a substance that can produce toxic effects" and a 'poisoning' as "a poison exposure that results in bodily harm". Exposures are categorized by intent. Unintentional poisonings are exposures that occur by accident such as a child ingesting a cleaning solution. Intentional poisonings are those exposures that result from a conscious decision to cause harm such as with suicide.

Those at greater risk of poisoning exposure are among children and particularly those years of age and younger for unintentional poisoning exposures. For these children, elevated blood levels as low as 10ug/dL is associated with negative effects on cognitive development, behavior and physical growth. Adolescents are at risk for both unintentional and intentional poisoning exposures. It is estimated that 50% of these are suicide attempts.

The most common poisoning exposures for adults are pain relievers, antidepressants, sedatives, bites/stings, and cleaning substances. Among children, the most common exposure are pain relievers, cleaning substances, personal care products, cosmetics, foreign bodies, plants, carbon monoxide (CO), and lead. Additionally CO is the most fatal unintentional poisonings compared to other agents. These occur during the winter months, generally more often in colder temperature climates. Exposure to CO causes sleepiness, dizziness and headaches. However a longer exposure can result in heart palpitations, nausea, and vomiting. Higher concentrations of CO can result in death.

National Poison Prevention Week: March 21-27, 2006.

This year's theme is "Children Act Fast...So Do Poisons." It emphasizes the responsibility of parents,

grandparents and other caregivers on poisoning prevention in the home. Physicians can help this effort by providing these caregivers the prevention tips below (provided by the American Association of Poison Control Centers and the CDC). Physicians can also order FREE packets of the California Poison Action Hotline stickers in English and Spanish from by calling 1-800-222-1222 or by visiting www.calpoison.org.

Make your home safer:

Post the poison control number 1-800-222-1222 on or near every home telephone.

Store all medicines, household products, and personal care products in locked cabinets that are out of reach of small children.

Know the names of the plants in your house and yard. Identify poisonous plants and place them out of reach of children or remove them.

Be aware of any medicines that visitors may bring into your home. Make sure visitors do not leave their medicines where children can find them easily, for example in an unattended purses or suitcase.

Monitor the air quality in your house. Place carbon monoxide monitors near the bedrooms in your house. (CPSC, 2002)

All combustion (fuel burning) appliances should be professionally installed and inspected annually. (CDC, 1995)

Check your house for lead-based paints. Contact the National Lead Information Center at 1-800-424-LEAD to receive more detailed information. (CDC, NCEH 2002)

Use poisonous products safely:

Always store household products in their original containers. Do not use food containers such as cups or bottles to store chemical products such as cleaning solutions or cosmetic products.

Always read the labels before using a potentially poisonous product. Never leave the product unattended while using it and return the product to the locked cabinet when you are finished.

When giving or taking medication make sure there is ample available light.

Avoid taking medicine in front of children because

Continued on page 12

Poison Prevention...from page 11

they tend to imitate adults.

Do not call medicine “candy.”

Follow label directions when taking medicines. Be aware of potential interactions with other medicines or alcohol and never share prescription drugs.

Turn on a fan and open windows when using chemical products.

Wear protective clothing (gloves, long pants, long sleeves, socks, shoes) when spraying pesticides and other chemicals.

Never mix household cleaning and chemical products together. A poisonous gas may be created when mixing chemicals.

Do not burn fuels or charcoal or use gasoline-powered engines in confined spaces such as garages, tents, or poorly ventilated rooms (CDC, 1982).

What to do if a poisoning exposure occurs:

Remain calm.

If you have a poison emergency and the victim has collapsed or is not breathing call 911. If you have a poison exposure and the victim is alert call the California Poison Action Line at 1-800-876-4766. Try to have the following information ready if possible:

- The person's age and estimated weight
- The container or bottle of the poisonous product, if available
- Time that the poison exposure occurred
- Your name and phone number

Follow the instructions from the emergency operator or the poison control center.

inSPOTLA.org: STD/HIV Partner Notification Goes Online

DHS and AIDS Healthcare Foundation (AHF) have launched inSPOTLA.org, a new, innovative STD/HIV partner notification tool. This website enables users to notify recipients of possible STD or HIV exposure by sending an electronic postcard or ‘e-card,’ either anonymously or with a personal note. inSPOTLA is an effective tool with the potential to increase partner notification for HIV and other STDs and, ultimately, lead to a significant decrease in disease incidence in the County.

Los Angeles County is the first jurisdiction to add HIV to its menu of STDs on an e-card partner notification system. inSPOTLA.org is part of a public health response to an alarming 8% increase in HIV cases among men who have sex with men (MSM) in 2004 and a rapid increase in the use of online “cruising” or dating sites to find partners.

“inSPOTLA.org certainly met the need for a more aggressive and targeted prevention effort,” said Peter R. Kemdt, MD, MPH, Director of the Sexually Transmitted Disease Program. “More importantly, this online tool supplements services we already provide offline and is available to everyone, including gay and bisexual men.”

Aimed at increasing early STD and HIV diagnosis and treatment and thereby reducing transmission, inSPOTLA is based on a successful program launched in San Francisco in 2004. Since then, usage data has shown an average of 750 people visiting the Bay Area site every day, with 500 e-cards sent per month. Fifty-one percent of those people receiving cards click through to the website for more information about testing and treatment. The response in L.A. County has been even greater. Since the launch, over 43,000 e-cards have been sent, with 19% of recipients clicking through for more information. This “click through rate” is expected to improve with increased publicity about inSPOTLA.org, which will encourage more people to take the e-card seriously and not mistake it for e-mail spam.

“This website will be a powerful tool in reducing the spread of STDs, including HIV, in Los Angeles County,” said Jonathan Fielding, MD, MPH, Public Health Director. “By giving people an easy way to notify their sex partners, inSPOTLA will enable more people to get tested and treated early for HIV and other STDs, preventing complications and helping stop the chain of infection.”

Botulism: On the Rise in Los Angeles County

Botulism is a serious paralytic illness that is always a public health emergency. Though still uncommon, the numbers of suspected and confirmed cases in Los Angeles County are increasing. In 2005, eleven suspected cases were reported and eight cases were confirmed, including two cases of foodborne botulism. Physicians must be aware of botulism's signs and symptoms, especially among injection drug users, and report suspected cases to the health department immediately for treatment and testing.

Nerve toxins produced by the bacterium *Clostridium botulinum* (and other clostridial species in some cases) cause three clinical forms of botulism: foodborne, wound, and intestinal (or infant) botulism.

Botulinum toxin is a Category A bioterrorism agent—those most likely to be used in bioterrorist activity. Deliberate contamination of food or water is possible, and while airborne transmission of toxin does not occur naturally, toxin inhalation has occurred in laboratory workers. Clinical manifestations of airborne toxin release are the same as foodborne botulism (minus the prodromal gastrointestinal symptoms).

Due to the heightened concern of bioterrorism acts, any suspected cases should be immediately reported to DHS's Acute Communicable Disease Control program (ACDC)—regardless of time of day—by telephone. If clinical and epidemiologic factors warrant, ACDC will authorize laboratory testing and provide botulinum antitoxin. If clinical suspicion for botulism is high and symptoms progress, administration of antitoxin **should not be delayed** pending serum, stool, or wound studies.

Suspected botulism cases should be reported immediately to
Acute Communicable Disease Control
213-240-7941 M-F 8am-5pm
213-974-1234 after hours and holidays

Infant botulism is managed by the
California Department of Health Services.
Contact them 24 hours a day at:
(510) 231-7600

Botulism Identification

Botulism is classically described as the acute onset of bilateral cranial neuropathies associated with symmetric descending weakness. Patients may exhibit some or all of the following symptoms: early—blurred vision, diplopia, and dry mouth; late—dysphonia, dysarthria, dysphagia, ptosis, symmetrical descending, progressive muscle weakness, and respiratory failure. Mental status and sensory function are usually normal and patients are afebrile unless a secondary infection is present (e.g., aspiration pneumonia). In foodborne botulism, symptoms generally begin 18 to 36 hours after eating a contaminated food, but may occur as early as 6 hours or as late as 10 days. Wound botulism occurs within days after injury.

The differential diagnosis for botulism includes: myasthenia gravis, Guillain-Barré syndrome, stroke, Lambert-Eaton myasthenic syndrome (LEMS), tick paralysis, poliomyelitis, and heavy metal intoxication.

The diagnosis of botulism requires a high index of suspicion. Important questions to ask of the patient are:

- recent history of eating either home-canned foods that are low-acid or foods that have been lightly preserved (such as fermented, salted or smoked fish);
- knowledge of other known individuals with similar symptoms;
- recent history of intravenous injection, subcutaneous “skin popping,” or any kind of wound.

Commercial food products and restaurants can be occasional sources.

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2006

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4–6 years	11–12 years	13–14 years	15 years	16–18 years
Hepatitis B ¹		HepB	HepB	HepB ¹			HepB					HepB Series			
Diphtheria, Tetanus, Pertussis ²			DTaP	DTaP	DTaP		DTaP			DTaP		Tdap		Tdap	
<i>Haemophilus influenzae</i> type b ³			Hib	Hib	Hib ²		Hib								
Inactivated Poliovirus			IPV	IPV			IPV			IPV					
Measles, Mumps, Rubella ⁴							MMR			MMR		MMR			
Varicella ⁵							Varicella					Varicella			
Meningococcal ⁶								Vaccines within broken line are for selected populations				MCV4		MCV4	
										MPSV4				MCV4	
Pneumococcal ⁷			PCV	PCV	PCV		PCV			PCV				PPV	
Influenza ⁸							Influenza (Yearly)					Influenza (Yearly)			
Hepatitis A ⁹												HepA Series			

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2005, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. ■ Indicates age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever

any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Range of recommended ages

Catch-up immunization

11–12 year old assessment

1. Hepatitis B vaccine (HepB). **AT BIRTH:** All newborns should receive monovalent HepB soon after birth and before hospital discharge. **Infants born to mothers who are HBsAg-positive** should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. **Infants born to mothers whose HBsAg status is unknown** should receive HepB within 12 hours of birth. The mother should have blood drawn as soon as possible to determine her HBsAg status; if HBsAg-positive, the infant should receive HBIG as soon as possible (no later than age 1 week). **For infants born to HBsAg-negative mothers**, the birth dose can be delayed in rare circumstances but only if a physician's order to withhold the vaccine and a copy of the mother's original HBsAg-negative laboratory report are documented in the infant's medical record. **FOLLOWING THE BIRTHDOSE:** The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. It is permissible to administer 4 doses of HepB (e.g., when combination vaccines are given after the birth dose); however, if monovalent HepB is used, a dose at age 4 months is not needed. **Infants born to HBsAg-positive mothers** should be tested for HBsAg and antibody to HBsAg after completion of the HepB series, at age 9–18 months (generally at the next well-child visit after completion of the vaccine series).

2. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap – adolescent preparation)** is recommended at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a Td booster dose. Adolescents 13–18 years who missed the 11–12-year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent **tetanus and diphtheria toxoids (Td)** are recommended every 10 years.

3. *Haemophilus influenzae* type b conjugate vaccine (Hib). Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be administered at age ≥12 months.

4. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by age 11–12 years.

5. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.

6. Meningococcal vaccine (MCV4). Meningococcal conjugate vaccine (MCV4) should be given to all children at the 11–12 year old visit as well as to unvaccinated adolescents at high school entry (15 years of age). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated, preferably with MCV4, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative. Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups (see *MMWR* 2005;54 [RR-7]:1-21); use MPSV4 for children aged 2–10 years and MCV4 for older children, although MPSV4 is an acceptable alternative.

7. Pneumococcal vaccine. The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months and for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000; 49(RR-9):1-35.

8. Influenza vaccine. Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], diabetes, and conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2005;54[RR-8]:1-55). In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–5 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2005;54(RR-8):1-55. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).



9. Hepatitis A vaccine (HepA). HepA is recommended for all children at 1 year of age (i.e., 12–23 months). The 2 doses in the series should be administered at least 6 months apart. States, counties, and communities with existing HepA vaccination programs for children 2–18 years of age are encouraged to maintain these programs. In these areas, new efforts focused on routine vaccination of 1-year-old children should enhance, not replace, ongoing programs directed at a broader population of children. HepA is also recommended for certain high risk groups (see *MMWR* 1999; 48[RR-12]:1-37).

The Childhood and Adolescent Immunization Schedule is approved by:

Advisory Committee on Immunization Practices www.cdc.gov/nip/acip • American Academy of Pediatrics www.aap.org • American Academy of Family Physicians www.aafp.org

Recommended Immunization Schedule for Children and Adolescents Who Start Late or Who Are More Than 1 Month Behind

The tables below give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.

CATCH-UP SCHEDULE FOR CHILDREN AGED 4 MONTHS THROUGH 6 YEARS					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Diphtheria, Tetanus, Pertussis	6 wks	4 weeks	4 weeks	6 months	6 months ¹
Inactivated Poliovirus	6 wks	4 weeks	4 weeks	4 weeks ²	
Hepatitis B ³	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Measles, Mumps, Rubella	12 mo	4 weeks ⁴			
Varicella	12 mo				
<i>Haemophilus influenzae</i> type b ⁵	6 wks	4 weeks if first dose given at age <12 months 8 weeks (as final dose) if first dose given at age 12–14 months No further doses needed if first dose given at age ≥15 months	4 weeks ⁶ if current age <12 months 8 weeks (as final dose) ⁶ if current age ≥12 months and second dose given at age <15 months No further doses needed if previous dose given at age ≥15 mo	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal ⁷	6 wks	4 weeks if first dose given at age <12 months and current age <24 months 8 weeks (as final dose) if first dose given at age ≥12 months or current age 24–59 months No further doses needed for healthy children if first dose given at age ≥24 months	4 weeks if current age <12 months 8 weeks (as final dose) if current age ≥12 months No further doses needed for healthy children if previous dose given at age ≥24 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	 

CATCH-UP SCHEDULE FOR CHILDREN AGED 7 YEARS THROUGH 18 YEARS			
Vaccine	Minimum Interval Between Doses		
	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Booster Dose
Tetanus, Diphtheria ⁸	4 weeks	6 months	6 months if first dose given at age <12 months and current age <11 years; otherwise 5 years
Inactivated Poliovirus ⁹	4 weeks	4 weeks	IPV ^{2,9}
Hepatitis B	4 weeks	8 weeks (and 16 weeks after first dose)	
Measles, Mumps, Rubella	4 weeks		
Varicella ¹⁰	4 weeks		

1. DTaP. The fifth dose is not necessary if the fourth dose was administered after the fourth birthday.

2. IPV. For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years. If both OPV and IPV were administered as part of a series, a total of 4 doses should be given, regardless of the child's current age.

3. HepB. Administer the 3-dose series to all children and adolescents <19 years of age if they were not previously vaccinated.

4. MMR. The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.

5. Hib. Vaccine is not generally recommended for children aged ≥5 years.

6. Hib. If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12–15 months and at least 8 weeks after the second dose.

7. PCV. Vaccine is not generally recommended for children aged ≥5 years.

8. Td. Adolescent tetanus, diphtheria, and pertussis vaccine (Tdap) may be substituted for any dose in a primary catch-up series or as a booster if age appropriate for Tdap. A five-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. See ACIP recommendations for further information.

9. IPV. Vaccine is not generally recommended for persons aged ≥18 years.

10. Varicella. Administer the 2-dose series to all susceptible adolescents aged ≥13 years.

Report adverse reactions to vaccines through the federal Vaccine Adverse Event Reporting System. For information on reporting reactions following immunization, please visit www.vaers.hhs.gov or call the 24-hour national toll-free information line 800-822-7967. Report suspected cases of vaccine-preventable diseases to your state or local health department.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Website at www.cdc.gov/nip or contact 800-CDC-INFO (800-232-4636) (In English, En Español — 24/7)

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THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County



COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

313 North Figueroa Street, Room 212
Los Angeles, California 90012

Selected Reportable Diseases (Cases)* - August - October 2005

Disease	THIS PERIOD Aug - Oct 2005	SAME PERIOD LAST YEAR Aug - Oct 2004	YEAR TO DATE OCT.		YEAR END TOTALS		
			2005	2004	2004	2003	2002
AIDS*	380	872	1,310	1,972	2,335	2,532	1,719
Amebiasis	26	29	99	82	98	121	102
Campylobacteriosis	209	250	638	807	915	1,100	1,067
Chlamydial Infections	10,458	10,202	3,469	32,418	38,464	36,555	35,688
Encephalitis	15	60	60	96	137	38	61
Gonorrhea	2,936	2,684	9,052	8,110	9,696	8,008	7,800
Hepatitis Type A	106	65	198	250	319	376	438
Hepatitis Type B, Acute	8	18	46	62	71	56	29
Hepatitis Type C, Acute	1	1	2	5	5	0	3
Measles	0	1	0	2	1	0	0
Meningitis, viral/aseptic	237	383	726	760	790	899	466
Meningococcal Infections	4	4	23	15	28	32	46
Mumps	3	0	10	2	2	10	16
Non-gonococcal Urethritis (NGU)	145	365	925	1,258	1,470	1,393	1,393
Pertussis	88	54	275	141	141	130	170
Rubella	0	0	0	0	0	0	0
Salmonellosis	384	348	864	876	1,185	995	956
Shigellosis	261	217	605	462	550	669	974
Syphilis, primary & secondary	134	115	489	378	459	442	364
Syphilis, early latent (<1 yr.)	120	94	448	313	381	365	353
Tuberculosis	226	219	620	621	856	949	1,025
Typhoid fever, Acute	5	3	12	13	13	16	33

* Case totals are provisional and may vary following periodic updates of the database.